



Conduent Fiscal Agent Services  
U.S. Department of Labor  
Provider Address Change Form

Please complete all sections on this form.

<b>Section A: General Information</b>		
Provider Name:		
Provider Number:		
Please check appropriate program: <input type="checkbox"/> DFELHWC (Division of Federal Employees', Longshore and Harbor Workers' Compensation) <input type="checkbox"/> DEEOIC (Division of Energy Employees Occupational Illness Compensation) <input type="checkbox"/> DCMWC (Division of Coal Mine Workers' Compensation)		
<b>Section B: Previous Address Information</b> <input type="checkbox"/> Physical/Practice <input type="checkbox"/> Billing/Remit		
Street Address:		
City:	State:	Zip:
Phone: (    )		
<b>Section C: New Address Information</b> <input type="checkbox"/> Physical/Practice <input type="checkbox"/> Billing/Remit		
Street Address:		
City:	State:	Zip:
Phone: (    )		
<b>Section D: Authorization</b>		
Signature:		Date:
Print Name:		
Title:		

**Return to:**  
Department of Labor  
Pharmacy Bill Processing, DFELHWC  
PO Box 8308  
London, KY 40742-8308

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Rev. 09-29-2020